STATE OF CONNECTICUT
State Innovation Model
Equity and Access Council

Meeting Summary
Thursday, December 18, 2014

Members Present: Ellen Andrews; Linda Barry; Peter Bowers; Alice Ferguson; Kristen Noelle-Hatcher; Gaye Hyre; Kate McEvoy, Donna O'Shea, Robert Russo, Victoria Veltri, Keith vom Eigen; Katherine Yacavone

Members Absent: Maritza Bond, Darcey Cobbs-Lomax; Barbara Headley; Deborah Hutton; Roy Lee; Erica Spatz; Robert Willig; Margaret Hynes

Other Participants: Mark Schaefer

Meeting was called to order at 6:10 p.m.

1. Introductions
Victoria Veltri chaired the meeting. Participants introduced themselves.

2. Public comment
Sheldon Toubman made comments about the adoption of under-service protections for Medicaid. He reinforced that DSS is the single state agency for Medicaid and cited federal statute concerning the decision-making role of the single entity. He endorsed a protocol developed by DSS and the SIM PMO regarding alignment of the work of the CMC and the EAC related to under-service, and the fact that DSS has ultimate authority over policies adopted for the Medicaid program.

3. Minutes
Due to the November 13th minutes not being distributed in advance, adoption of minutes was postponed.

4. EAC Roadmap

Adam Stolz from Chartis introduced himself as a facilitator and resource for the EAC's work. He made prefatory remarks about the goals of the meeting, how to meet the EAC's charge, and what activities are required.

Kathy Yacavone asked about whether the EAC is responsible for all populations, including the uninsured, and suggested considering implications for under-service for all populations. Mark Schaefer noted that the SIM proposal to CMMI is focused on covered populations due to the centrality of payment reform, but that many benefits of the reforms (e.g. quality, care experience enhancement) will accrue to all populations including the uninsured. There was a lengthy discussion about the extent to which uninsured should be included in SIM and in the EAC's work.

Mr. Stolz facilitated a discussion about the EAC's charge and noted the group's intent to focus on "Phase I" questions described in the charter, which are focused on devising appropriate safeguards against under-service and patient selection.

The group discussed removing reference to "evidence-based" care decisions from the EAC charter, which will be done. SIM HISC had debated whether "evidence-based" should be the standard against which under-service is considered and decided the issue should be left to the EAC to consider.

Peter Bowers asked about participation of Medicare fee-for-service in the SIM program. Dr. Schaefer commented that Medicare was invited to participate in SIM councils but due to bandwidth limitations, has declined such invitations from SIM states including Connecticut. Some workstreams, including the EAC's, can apply to Medicare, whereas others such as value-based insurance design, will not.

Kate McEvoy asked to clarify the EAC's charge with respect to the nature of its recommendations and the mechanism by which they will be enacted. Will the recommendations be aspirational or mandatory? Dr. Schaefer explained that we did not propose legislative action for most areas of SIM, though this remains an option if deemed appropriate. We are investing in a collaborative process that will result in recommendations, and we believe the payers will support these recommendations if this process is successful. EAC/SIM will also urge adoption of these recommendations. There was discussion about the EAC's role in making a business case to payers for why under-service matters.

Robert Russo expressed concern about defining and measuring under-service in a way that is relevant for a heterogeneous population that also shifts its insurance status over time. He asked about how we will determine that a given consumer is under-served in the commercial population, and then how will we do this in Medicare or Medicaid where access is already limited? He stated that this is further complicated by the creation of narrower networks that limit access. He commented that he believes a shared savings program (SSP) in Medicaid would create an incentive not to provide services.

Dr. Bowers discussed challenges with measuring patient experience (i.e. rating physicians) and found that ratings of doctors, with the exception of some "outliers" was inflated,

Keith vom Eigem noted that there is a way to measure care experience; that's what CAHPS was intended to do.

The group discussed elements of the charter and the specific charge, reviewing the content of the presentation.

Mr. Stolz asked about any existing initiatives of which the group is aware, that are also addressing the question of preventing under-service and patient selection in Connecticut.

Gaye Hyre noted that the cost of healthcare continues to be a greater burden to individuals as noted in a recent New York Times article. Ms. McEvoy noted the need to utilize a range of strategies,

including current tools, such as how DSS currently uses mystery shopper and CAHPS. Ellen Andrews noted that the MAPOC Complex Care Committee (CCC) had great success in defining under-service measures. The group briefly discussed the Clifford Beers Innovations grant wraparound initiative (not ready yet) and the DMHAS health homes initiative. Ms. McEvoy agreed that it would be useful to do some inventorying. She mentioned a group in the north end of Hartford this is doing community interviewing across a range of domainsas a collaboration with Cigna. Ms. Yacavone noted that the work of local health departments to assess community needs and barriers to care might be relevant. Dr. vom Eigem suggested looking at the Communities of Care Program; organizing programs locally to coordinate care more closely and working withCT Partners for Health (led by Qualidigm). Ms. Veltri asked about the application of hospital community health needs assessments to our work and the strategies of the Partnershp for Strong Communities to address the needs of the chronically homeless in the CT population through their Innovations grant application. Dr. Andrews noted that CHA has done a lot to coordinate findings in this area.

Mr. Stolz proposed a timeline for the EAC to issue recommendations pursuant to its charge. Working backwards from the administration's commitment in the SIM program to implement a range of initiatives including QISSP for calendar year 2016, he proposed issuing recommendations by the end of March 2015 in order to allow time for review, adoption, testing, and preparation on the part of numerous stakeholders (e.g. payers, providers). In addition, Chartis has been engaged to provide intense support to the EAC through March, though that will not dictate the deadline.

Ms. Hyre asked about the need for legislation. A group discussion followed. There were comments about limitations of legislation due to the fact that over half of the covered population is enrolled in self-funded clients, and Dr. Andrews noted that legislation would inspire resistance among key participants.

Dr. Bowers cautioned that alignment or convergence of efforts should be viewed as an end point (2018) of SIM rather than a starting point (2016). He noted that adopting a uniform set of measures will take time, especially for the numerous ASO (self-funded) clients that need to be engaged in order to implement. Dr. Bowers also suggested that the group should seek to distinguish between a FFS baseline and the outcomes that ensue from shifting to an SSP model. This will ensure that we address the question specifically put to the group rather than trying to solve for the entire problem of healthcare equity and access as it currently exists.

Dr. Andrews noted that we're not proposing all payers adopt safeguards by the end of March; just that the EAC would issue recommendations.

Dr. vom Eigem asked how we would distinguish effects of payment reform vs. effects of other changes. He asked about how we hold someone accountable for local limitations in capacity. Who is accountable for the absence or reduction of services? We have to take these things into account, measure these things, and determine what we can do to address them.

Ms. Yacavone asked about how we slice these basic access questions. Is it by geography, by race/ethnicity, by levels of care, urban vs rural? In the DPH state health improvement plan process there were 5 or 6 views that were cross-cutting themes.

Dr. Andrews suggested that we start with the care people are getting, and then talk about what the downsides are to changing the system. There are some things that should never happen once. She cautioned against over-complicating the issue or trying to take on every problem.

Ms. Yacavone noted that access to specialty care is a different issue. Our purpose is to focus on measurable transformational issues. Harder to parse out each question, but somehow we have to do that.

Mr. Stolz agreed that we are here as part of a governance process to address reforms that the SIM proposes to enact. The question for "Phase I" is what needs to be in place to ensure that we avoid harm as a byproduct of SIM reforms. Phase 2 might be how we can leverage the reforms to maximize their benefit with respect to equity and access.

Dr. Bowers agreed that the focus is necessary to get our initial core charge accomplished. Dr. Russo asked whether the question of under-service isn't really about network adequacy, which in turn varies based on the local population. Mr. Stolz agreed that network adequacy is addressed in the charter as a "Phase 2" question.

Ms. Veltri suggested that the group think about the problem in terms of two questions. First, when you get through the door, are you getting what you need (and why aren't you getting it if you don't get it). Secondarily, canone even get to the doctor.

Dr. Bowers noted that the legacy environment for commercially insured patients is you can walk through many doors to access care. The new approach is a change in choices or options around access when a consumer makes a certain decision. Dr. Russo commented that we are now talking about tiered or narrow networks, which restrict those choices for patients.

5. Development of Recommendations: Progress to Date and Next Steps

Mr. Stolz facilitated a discussion about what research is required for the group to deliberate and make informed decisions in order to reach recommendations. Starting with the questions contained in the EAC charter, the group discussed the extent to which they had been addressed to date, and ways of potentially answering them.

The group agreed that we should do a literature review to see if any information is available for questions 1 and 2 in the charter concerning risk assessment. The group agreed that some of the questions are hard to measure; there's a reason they haven't been done. There are inherent challenges in getting a good baseline when all of this is new. Dr. Andrews noted that we have not really looked at Program Integrity. Dr. Bowers asked how existing tools that payers use could apply to under-service. Dr. Schaefer suggested that the tools are really about identifying outliers, which could be applicable to under-service. Dr. Bowers suggested that the area of focus should be unwanted variation in care (i.e. from the Crystal Run example) and we should be looking at over

and under-service together. The group agreed that the question in the charter concerning "other methods" of detecting patient selection (e.g. mystery shopper) should also be applied to under-service.

Dr. Andrews noted a requirement under NCQA PCMH that you have an under-service monitoring system. She called 7 existing ACO groups and only Crystal Run was actively monitoring under service.. Others are monitoring more informally via peer review, file review. She said it would be great to find out what is out there today, in terms of what CT's ACOs are doing.

Mr. Stolz asked about the group's suggestions for organizing the work using one or more ways to segment the problem statement and potential solutions.

Ms. Veltri asked if we can make use of the CCC work, and other research done to date. Dr. Andrews noted that the CCC work has limited applicability here because the underlying populations are so different (i.e. don't need care plans for general population).

Ms. McEvoy asked about the scope of the EAC's authority. There was discussion about how we cannot easily regulate payers with respect to all of their business. There are also mechanisms for regulating providers.

Dr. Bowers commented that when information is fully transparent within a care delivery environment, the types of risks with which the EAC is concerned will melt away. He said when anyone can look at a provider's data, providers can't afford not to be working on these things; can't afford to have big gaps in their care delivery. Crystal Run has engineered this type of environment. Dr. Schaefer suggested that perhaps these are capabilities that we should ask ACOs to demonstrate as a condition of participation.

Mr. Stolz proposed a process that utilizes groups that convene off-line to study particular topics. Dr. Andrews proposed a group to look at risk profiles and risk adjustment of ACO populations over time. A lowering of risk would suggest patient selection, and this could be monitored. Dr. Andrews and Dr. Russo noted the importance of the EAC being able to see all of the work and follow what is going on in sub-groups. Ms. Yacavone stressed the need to be clear about the expectations of sub-groups and members.

6. Meeting Logistics

Mr. Stolz asked the group about the reasons for lack of attendance at prior EAC meetings. Both logistical reasons and substantive reasons (i.e. objectives for a given meeting not clear) were cited.

Mr. Stolz proposed a meeting schedule going forward. The group agreed with the schedule provided that we check for conflicts with holidays, and suggested that we consider holding some of the meetings via an e-meeting format. Dr. Andrews suggested that we take advantage of work that can be done other than through a meeting, such as through email exchange of documents, especially for sub-groups. Mr. Stolz noted that Chartis will support the meeting preparation and offline work in order to meet the March timeline for developing the EAC's recommendations. He will be

reaching out to each EAC member individually to schedule one on one discussions about members' expectations, perspectives on the subjects to be addressed, and ways they would like to contribute.

Meeting was adjourned at 8:15pm.